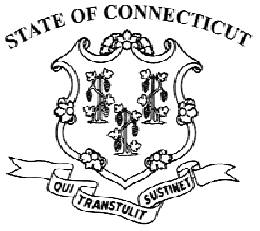

Substitute Senate Bill No. 1205

Public Act No. 05-102

AN ACT CONCERNING APPEALS OF DENIALS OR DETERMINATIONS BY MANAGED CARE ORGANIZATIONS AND RENAMING THE OFFICE OF MANAGED CARE OMBUDSMAN.

Be it enacted by the Senate and House of Representatives in General Assembly convened:

Section 1. Subdivision (1) of subsection (b) of section 38a-478n of the general statutes is repealed and the following is substituted in lieu thereof (*Effective October 1, 2005*):

(b) (1) To appeal a denial or determination pursuant to this section an enrollee or any provider acting on behalf of an enrollee shall, not later than thirty days after receiving final written notice of the denial or determination from the enrollee's managed care organization or utilization review company, file a written request with the commissioner. The appeal shall be on forms prescribed by the commissioner and shall include the filing fee set forth in subdivision (2) of this subsection and a general release executed by the enrollee for all medical records pertinent to the appeal. The managed care organization or utilization review company named in the appeal shall also pay to the commissioner the filing fee set forth in subdivision (2) of this subsection. <u>If the Insurance Commissioner receives three or more appeals of denials or determinations by the same managed care organization or utilization review company with respect to the same</u>

procedural or diagnostic coding, the Insurance Commissioner may, on said commissioner's own motion, issue an order specifying how such managed care organization or utilization review company shall make determinations about such procedural or diagnostic coding.

Sec. 2. Subsection (e) of section 17b-427 of the general statutes is repealed and the following is substituted in lieu thereof (*Effective October 1, 2005*):

(e) Not later than June 1, 2001, and annually thereafter, the Insurance Commissioner, in conjunction with the **[**Managed Care Ombudsman**]** Healthcare Advocate, shall submit to the Governor and to the joint standing committees of the General Assembly having cognizance of matters relating to human services and insurance and to the select committee of the General Assembly having cognizance of matters relating to aging, a list of those Medicare organizations that have failed to file any data, reports or information requested pursuant to subsection (c) of this section.

Sec. 3. Section 38a-47 of the general statutes is repealed and the following is substituted in lieu thereof (*Effective October 1, 2005*):

All domestic insurance companies and other domestic entities subject to taxation under chapter 207 shall, in accordance with section 38a-48, as amended by this act, annually pay to the Insurance Commissioner, for deposit in the Insurance Fund established under section 38a-52a, an amount equal to the actual expenditures made by the Insurance Department during each fiscal year, and the actual expenditures made by the Office of the **[**Managed Care Ombudsman**]** Healthcare Advocate, including the cost of fringe benefits for department and office personnel as estimated by the Comptroller, plus the expenditures made on behalf of the department and the office from the Capital Equipment Purchase Fund pursuant to section 4a-9 for such year, but excluding expenditures paid for by fraternal benefit

societies, foreign and alien insurance companies and other foreign and alien entities under sections 38a-49 and 38a-50. Payments shall be made by assessment of all such domestic insurance companies and other domestic entities calculated and collected in accordance with the provisions of section 38a-48, as amended by this act. Any such domestic insurance company or other domestic entity aggrieved because of any assessment levied under this section may appeal therefrom in accordance with the provisions of section 38a-52.

Sec. 4. Section 38a-48 of the general statutes is repealed and the following is substituted in lieu thereof (*Effective October 1, 2005*):

(a) On or before June thirtieth, annually, the Commissioner of Revenue Services shall render to the Insurance Commissioner a statement certifying the amount of taxes or charges imposed on each domestic insurance company or other domestic entity under chapter 207 on business done in this state during the preceding calendar year; the statement for local domestic insurance companies shall set forth the amount of taxes and charges before any tax credits allowed as provided in section 12-202.

(b) On or before July thirty-first, annually, the Insurance Commissioner and the Office of the **[**Managed Care Ombudsman**]** Healthcare Advocate shall render to each domestic insurance company or other domestic entity liable for payment under section 38a-47, as amended by this act, (1) a statement which includes the amount appropriated to the Insurance Department and the Office of the **[**Managed Care Ombudsman**]** Healthcare Advocate for the fiscal year beginning July first of the same year, the cost of fringe benefits for department and office personnel for such year, as estimated by the Comptroller, and the estimated expenditures on behalf of the department and the office from the Capital Equipment Purchase Fund pursuant to section 4a-9 for such year, (2) a statement of the total taxes imposed on all domestic insurance companies and domestic insurance

entities under chapter 207 on business done in this state during the preceding calendar year, and (3) the proposed assessment against that company or entity, calculated in accordance with the provisions of subsection (c) of this section, provided that for the purposes of this calculation the amount appropriated to the Insurance Department and the Office of the **[**Managed Care Ombudsman**]** Healthcare Advocate plus the cost of fringe benefits for department and office personnel and the estimated expenditures on behalf of the department and the office from the Capital Equipment Purchase Fund pursuant to section 4a-9 shall be deemed to be the actual expenditures of the department and the office.

(c) (1) The proposed assessments for each domestic insurance company or other domestic entity shall be calculated by (A) allocating twenty per cent of the amount to be paid under section 38a-47, as amended by this act, among the domestic entities organized under sections 38a-199 to 38a-209, inclusive, and 38a-214 to 38a-225, inclusive, in proportion to their respective shares of the total taxes and charges imposed under chapter 207 on such entities on business done in this state during the preceding calendar year, and (B) allocating eighty per cent of the amount to be paid under section 38a-47, as amended by this act, among all domestic insurance companies and domestic entities other than those organized under sections 38a-199 to 38a-209, inclusive, and 38a-214 to 38a-225, inclusive, in proportion to their respective shares of the total taxes and charges imposed under chapter 207 on such domestic insurance companies and domestic entities on business done in this state during the preceding calendar year, provided if there are no domestic entities organized under sections 38a-199 to 38a-209, inclusive, and 38a-214 to 38a-225, inclusive, at the time of assessment, one hundred per cent of the amount to be paid under section 38a-47, as amended by this act, shall be allocated among such domestic insurance companies and domestic entities. (2) When the amount any such company or entity is assessed pursuant to this

section exceeds twenty-five per cent of the actual expenditures of the Insurance Department and the Office of the **[**Managed Care Ombudsman**]** Healthcare Advocate, such excess amount shall not be paid by such company or entity but rather shall be assessed against and paid by all other such companies and entities in proportion to their respective shares of the total taxes and charges imposed under chapter 207 on business done in this state during the preceding calendar year. The provisions of this subdivision shall not be applicable to any corporation which has converted to a domestic mutual insurance company pursuant to section 38a-155 upon the effective date of any public act which amends said section to modify or remove any restriction on the business such a company may engage in, for purposes of any assessment due from such company on and after such effective date.

(d) For purposes of calculating the amount of payment under section 38a-47, as amended by this act, as well as the amount of the assessments under this section, the "total taxes imposed on all domestic insurance companies and other domestic entities under chapter 207" shall be based upon the amounts shown as payable to the state for the calendar year on the returns filed with the Commissioner of Revenue Services pursuant to chapter 207; with respect to calculating the amount of payment and assessment for local domestic insurance companies, the amount used shall be the taxes and charges imposed before any tax credits allowed as provided in section 12-202.

(e) On or before September thirtieth, annually, for each fiscal year ending prior to July 1, 1990, the Insurance Commissioner and the **[**Managed Care Ombudsman**]** Healthcare Advocate, after receiving any objections to the proposed assessments and making such adjustments as in their opinion may be indicated, shall assess each such domestic insurance company or other domestic entity an amount equal to its proposed assessment as so adjusted. Each domestic

insurance company or other domestic entity shall pay to the Insurance Commissioner on or before October thirty-first an amount equal to fifty per cent of its assessment adjusted to reflect any credit or amount due from the preceding fiscal year as determined by the commissioner under subsection (g) of this section. Each domestic insurance company or other domestic entity shall pay to the Insurance Commissioner on or before the following April thirtieth, the remaining fifty per cent of its assessment.

(f) On or before September first, annually, for each fiscal year ending after July 1, 1990, the Insurance Commissioner and the **[**Managed Care Ombudsman**]** Healthcare Advocate, after receiving any objections to the proposed assessments and making such adjustments as in their opinion may be indicated, shall assess each such domestic insurance company or other domestic entity an amount equal to its proposed assessment as so adjusted. Each domestic insurance company or other domestic entity shall pay to the Insurance Commissioner (1) on or before June 30, 1990, and on or before June thirtieth annually thereafter, an estimated payment against its assessment for the following year equal to twenty-five per cent of its assessment for the fiscal year ending such June thirtieth, (2) on or before September thirtieth, annually, twenty-five per cent of its assessment adjusted to reflect any credit or amount due from the preceding fiscal year as determined by the commissioner under subsection (g) of this section, and (3) on or before the following December thirty-first and March thirty-first, annually, each domestic insurance company or other domestic entity shall pay to the Insurance Commissioner the remaining fifty per cent of its proposed assessment to the department in two equal installments.

(g) Immediately following the close of the fiscal year, the Insurance Commissioner and the **[**Managed Care Ombudsman**]** Healthcare Advocate shall recalculate the proposed assessment for each domestic

insurance company or other domestic entity in accordance with subsection (c) of this section using the actual expenditures made by the Insurance Department and the Office of the **[**Managed Care Ombudsman**]** Healthcare Advocate during that fiscal year and the actual expenditures made on behalf of the department and the office from the Capital Equipment Purchase Fund pursuant to section 4a-9. On or before July thirty-first, the Insurance Commissioner and the **[**Managed Care Ombudsman**]** Healthcare Advocate shall render to each such domestic insurance company and other domestic entity a statement showing the difference between their respective recalculated assessments and the amount they have previously paid. On or before August thirty-first, the Insurance Commissioner and the **[**Managed Care Ombudsman**]** Healthcare Advocate, after receiving any objections to such statements, shall make such adjustments which in their opinion may be indicated, and shall render an adjusted assessment, if any, to the affected companies.

(h) If any assessment is not paid when due, a penalty of ten dollars shall be added thereto, and interest at the rate of six per cent per annum shall be paid thereafter on such assessment and penalty.

(i) The commissioner shall deposit all payments made under this section with the State Treasurer. On and after June 6, 1991, the moneys so deposited shall be credited to the Insurance Fund established under section 38a-52a and shall be accounted for as expenses recovered from insurance companies.

Sec. 5. Subsection (f) of section 38a-478n of the general statutes is repealed and the following is substituted in lieu thereof (*Effective October 1, 2005*):

(f) Not later than January 1, 2000, the Insurance Commissioner shall develop a comprehensive public education outreach program to educate health insurance consumers of the existence of the appeals

procedure established in this section. The program shall maximize public information concerning the appeals procedure and shall include, but not be limited to: (1) The dissemination of information through mass media, interactive approaches and written materials; (2) involvement of community-based organizations in developing messages and in devising and implementing education strategies; and (3) periodic evaluations of the effectiveness of educational efforts. The **[**Managed Care Ombudsman**]** Healthcare Advocate shall coordinate the outreach program and oversee the education process.

Sec. 6. Section 38a-479ee of the general statutes is repealed and the following is substituted in lieu thereof (*Effective October 1, 2005*):

(a) If the Insurance Commissioner determines that a preferred provider network or managed care organization, or both, has not complied with any applicable provision of this part, sections 38a-226 to 38a-226d, inclusive, or sections 38a-815 to 38a-819, inclusive, the commissioner may (1) order the preferred provider network or managed care organization, or both if both have not complied, to cease and desist all operations in violation of this part or said sections; (2) terminate or suspend the preferred provider network's license; (3) institute a corrective action against the preferred provider network or managed care organization, or both if both have not complied; (4) order the payment of a civil penalty by the preferred provider network or managed care organization, or both if both have not complied, of not more than one thousand dollars for each and every act or violation; (5) order the payment of such reasonable expenses as may be necessary to compensate the commissioner in conjunction with any proceedings held to investigate or enforce violations of this part, sections 38a-226 to 38a-226d, inclusive, or sections 38a-815 to 38a-819, inclusive; and (6) use any of the commissioner's other enforcement powers to obtain compliance with this part, sections 38a-226 to 38a-226d, inclusive, or sections 38a-815 to 38a-819, inclusive. The commissioner may hold a

hearing concerning any matter governed by this part, sections 38a-226 to 38a-226d, inclusive, or sections 38a-815 to 38a-819, inclusive, in accordance with section 38a-16. Subject to the same confidentiality and liability protections set forth in subsections (c) and (k) of section 38a-14, the commissioner may engage the services of attorneys, appraisers, independent actuaries, independent certified public accountants or other professionals and specialists to assist the commissioner in conducting an investigation under this section, the cost of which shall be borne by the managed care organization or preferred provider network, or both, that is the subject of the investigation.

(b) If a preferred provider network fails to comply with any applicable provision of this part, sections 38a-226 to 38a-226d, inclusive, or sections 38a-815 to 38a-819, inclusive, the commissioner may assign or require the preferred provider network to assign its rights and obligations under any contract with participating providers in order to ensure that covered benefits are provided.

(c) The commissioner shall receive and investigate (1) any grievance filed against a preferred provider network or managed care organization, or both, by an enrollee or an enrollee's designee concerning matters governed by this part, sections 38a-226 to 38a-226d, inclusive, or sections 38a-815 to 38a-819, inclusive, or (2) any referral from the Office of **[**Managed Care Ombudsman**]** the Healthcare Advocate pursuant to section 38a-1041, as amended by this act. The commissioner shall code, track and review such grievances and referrals. The preferred provider network or managed care organization, or both, shall provide the commissioner with all information necessary for the commissioner to investigate such grievances and referrals. The information collected by the commissioner pursuant to this section shall be maintained as confidential and shall not be disclosed to any person except (A) to the extent necessary to carry out the purposes of this part, sections 38a-226

to 38a-226d, inclusive, or sections 38a-815 to 38a-819, inclusive, (B) as allowed under this title, (C) to the **[**Managed Care Ombudsman**]** Healthcare Advocate and (D) information concerning the nature of any grievance or referral and the commissioner's final determination shall be a public record, as defined in section 1-200, provided no personal information, as defined in section 38a-975, shall be disclosed. The commissioner shall report to the **[**Managed Care Ombudsman**]** Healthcare Advocate on the resolution of any matter referred to the commissioner by the **[**Managed Care Ombudsman**]** Healthcare Advocate.

Sec. 7. Section 38a-479ff of the general statutes is repealed and the following is substituted in lieu thereof (*Effective October 1, 2005*):

No health insurer, Healthcare center, utilization review company, as defined in section 38a-226, or preferred provider network, as defined in section 38a-479aa, shall take or threaten to take any adverse personnel or coverage-related action against any enrollee, provider or employee in retaliation for such enrollee, provider or employee (1) filing a complaint with the Insurance Commissioner or the Office of **[**Managed Care Ombudsman**]** the Healthcare Advocate, or (2) disclosing information to the Insurance Commissioner concerning any violation of this part, sections 38a-226 to 38a-226d, inclusive, or sections 38a-815 to 38a-819, inclusive, unless such disclosure violates the provisions of chapter 705 or the privacy provisions of the federal Health Insurance Portability and Accountability Act of 1996 (P.L. 104-191) (HIPAA), as amended from time to time, or regulations adopted thereunder. Any enrollee, provider or employee who is aggrieved by a violation of this section may bring a civil action in the Superior Court to recover damages and attorneys' fees and costs.

Sec. 8. Section 38a-1041 of the general statutes is repealed and the following is substituted in lieu thereof (*Effective October 1, 2005*):

(a) There is established an Office of **[**Managed Care Ombudsman**]** the Healthcare Advocate which shall be within the Insurance Department for administrative purposes only.

(b) The Office of **[**Managed Care Ombudsman**]** the Healthcare Advocate may:

(1) Assist health insurance consumers with managed care plan selection by providing information, referral and assistance to individuals about means of obtaining health insurance coverage and services;

(2) Assist health insurance consumers to understand their rights and responsibilities under managed care plans;

(3) Provide information to the public, agencies, legislators and others regarding problems and concerns of health insurance consumers and make recommendations for resolving those problems and concerns;

(4) Assist consumers with the filing of complaints and appeals, including filing appeals with a managed care organization's internal appeal or grievance process and the external appeal process established under section 38a-478n, as amended by this act;

(5) Analyze and monitor the development and implementation of federal, state and local laws, regulations and policies relating to health insurance consumers and recommend changes it deems necessary;

(6) Facilitate public comment on laws, regulations and policies, including policies and actions of health insurers;

(7) Ensure that health insurance consumers have timely access to the services provided by the office;

(8) Review the health insurance records of a consumer who has

provided written consent for such review;

(9) Create and make available to employers a notice, suitable for posting in the workplace, concerning the services that the **[**Managed Care Ombudsman**]** Healthcare Advocate provides;

(10) Establish a toll-free number, or any other free calling option, to allow customer access to the services provided by the **[**Managed Care Ombudsman**]** Healthcare Advocate;

(11) Pursue administrative remedies on behalf of and with the consent of any health insurance consumers;

(12) Adopt regulations, pursuant to chapter 54, to carry out the provisions of sections 38a-1040 to 38a-1050, inclusive; and

(13) Take any other actions necessary to fulfill the purposes of sections 38a-1040 to 38a-1050, inclusive.

(c) The Office of **[**Managed Care Ombudsman**]** the Healthcare Advocate shall make a referral to the Insurance Commissioner if the **[**Managed Care Ombudsman**]** Healthcare Advocate finds that a preferred provider network may have engaged in a pattern or practice that may be in violation of sections 38a-226 to 38a-226d, inclusive, 38a-479aa to 38a-479gg, inclusive, or 38a-815 to 38a-819, inclusive.

(d) The **[**Managed Care Ombudsman**]** Healthcare Advocate and the Insurance Commissioner shall jointly compile a list of complaints received against managed care organizations and preferred provider networks and the commissioner shall maintain the list, except the names of complainants shall not be disclosed if such disclosure would violate the provisions of section 4-61dd or 38a-1045, as amended by this act.

Sec. 9. Section 38a-1042 of the general statutes is repealed and the

following is substituted in lieu thereof (*Effective October 1, 2005*):

(a) The Office of **[**Managed Care Ombudsman**]** the Healthcare Advocate shall be under the direction of the **[**Managed Care Ombudsman**]** Healthcare Advocate who shall be appointed by the Governor, with the approval of the General Assembly. The **[**Managed Care Ombudsman**]** Healthcare Advocate shall be an elector of the state with expertise and experience in the fields of Healthcare, health insurance and advocacy for the rights of consumers, provided the **[**ombudsman**]** Healthcare Advocate shall not have served as a director or officer of a managed care organization within two years of appointment. In addition to the **[**Managed Care Ombudsman**]** Healthcare Advocate, the Office of **[**Managed Care Ombudsman**]** the Healthcare Advocate shall consist of a staff of not more than three persons, which staff may be increased as the requirements and resources of the office permit.

(b) The Governor shall make the initial appointment of **[**Managed Care Ombudsman**]** the Healthcare Advocate from a list of candidates prepared and submitted, not later than June 1, 2000, to the Governor by the advisory committee established pursuant to section 38a-1049, as amended by this act. The Governor shall notify the advisory committee of the pending expiration of the term of an incumbent **[**ombudsman**]** Healthcare Advocate not less than ninety days prior to the final day of the **[**ombudsman's**]** Healthcare Advocate's term in office. If a vacancy occurs in the position of **[**ombudsman**]** Healthcare Advocate, the Governor shall notify the advisory committee immediately of the vacancy. The advisory committee shall meet to consider qualified candidates for the position of **[**ombudsman**]** Healthcare Advocate and shall submit a list of not more than five candidates to the Governor ranked in order of preference, not more than sixty days after receiving notice from the Governor of the pending expiration of the **[**ombudsman's**]** Healthcare Advocate's term or the occurrence of a

vacancy. The Governor shall designate, not more than sixty days after receipt of the list of candidates from the advisory committee, one candidate from the list for the position of **[**ombudsman**]** Healthcare Advocate. If, after the list is submitted to the Governor by the advisory committee, any candidate withdraws from consideration, the Governor shall designate a candidate from those remaining on the list. If the Governor fails to designate a candidate within sixty days of receipt of the list from the advisory committee, the advisory committee shall refer the candidate with the highest ranking on the list to the General Assembly for confirmation. If the General Assembly is not in session at the time of the Governor's or advisory committee's designation of a candidate, the candidate shall serve as the acting **[**ombudsman**]** Healthcare Advocate until the General Assembly meets and confirms the candidate as **[**ombudsman**]** Healthcare Advocate. A candidate serving as acting **[**ombudsman**]** Healthcare Advocate is entitled to compensation and has all the powers, duties and privileges of the **[**ombudsman**]** Healthcare Advocate. **[**An ombudsman**]** A Healthcare Advocate shall serve a term of four years, not including any time served as acting **[**ombudsman**]** Healthcare Advocate, and may be reappointed by the Governor or shall remain in the position until a successor is confirmed. Although an incumbent **[**ombudsman**]** Healthcare Advocate may be reappointed, the Governor shall also consider additional candidates from a list submitted by the advisory committee as provided in this section.

(c) Upon a vacancy in the position of the **[**ombudsman**]** Healthcare Advocate, the most senior attorney in the Office of **[**Managed Care Ombudsman**]** the Healthcare Advocate shall serve as the acting **[**ombudsman**]** Healthcare Advocate until the vacancy is filled pursuant to subsection (a) or (b) of this section. The acting **[**ombudsman**]** Healthcare Advocate has all the powers, duties and privileges of the **[**ombudsman**]** Healthcare Advocate.

Sec. 10. Section 38a-1043 of the general statutes is repealed and the following is substituted in lieu thereof (*Effective October 1, 2005*):

(a) Each managed care organization shall, when presented with the written consent of the consumer or the consumer's guardian or legal representative, provide to the Office of **[**Managed Care Ombudsman**]** the Healthcare Advocate access to records relating to such consumer.

(b) Any records provided pursuant to this section to the Office of **[**Managed Care Ombudsman**]** the Healthcare Advocate shall be exempt from disclosure under the Freedom of Information Act, as defined in section 1-200.

Sec. 11. Section 38a-1044 of the general statutes is repealed and the following is substituted in lieu thereof (*Effective October 1, 2005*):

All state agencies shall comply with reasonable requests of the Office of **[**Managed Care Ombudsman**]** the Healthcare Advocate for information and assistance.

Sec. 12. Section 38a-1045 of the general statutes is repealed and the following is substituted in lieu thereof (*Effective October 1, 2005*):

In the absence of the written consent of a consumer utilizing the services of the Office of **[**Managed Care Ombudsman**]** the Healthcare Advocate or such consumer's guardian or legal representative or of a court order, the Office of **[**Managed Care Ombudsman**]** the Healthcare Advocate, its employees and agents, shall not disclose the identity of the consumer.

Sec. 13. Section 38a-1046 of the general statutes is repealed and the following is substituted in lieu thereof (*Effective October 1, 2005*):

Each employer, other than a self-insured employer, that provides health insurance benefits to employees shall obtain from the **[**Managed

Care Ombudsman**]** Healthcare Advocate and post, in a conspicuous location, a notice concerning the services that the **[**Managed Care Ombudsman**]** Healthcare Advocate provides.

Sec. 14. Section 38a-1047 of the general statutes is repealed and the following is substituted in lieu thereof (*Effective October 1, 2005*):

(a) No **[**ombudsman**]** Healthcare Advocate or person employed by the Office of **[**Managed Care Ombudsman**]** the Healthcare Advocate may:

(1) Have a direct involvement in the licensing, certification or accreditation of a managed care organization;

(2) Have a direct ownership or investment interest in a managed care organization;

(3) Be employed by or participate in the management of a managed care organization; or

(4) Receive or have the right to receive, directly or indirectly, remuneration under a compensation arrangement with a managed care organization.

(b) No **[**ombudsman**]** Healthcare Advocate or person employed by the Office of **[**Managed Care Ombudsman**]** the Healthcare Advocate may knowingly accept employment with a managed care organization for a period of one year following termination of that person's services with the Office of **[**Managed Care Ombudsman**]** the Healthcare Advocate.

Sec. 15. Section 38a-1048 of the general statutes is repealed and the following is substituted in lieu thereof (*Effective October 1, 2005*):

(a) The Office of **[**Managed Care Ombudsman**]** the Healthcare Advocate may apply for and accept grants, gifts and bequests of funds

from other states, federal and interstate agencies and independent authorities and private firms, individuals and foundations, for the purpose of carrying out its responsibilities.

(b) There is established within the General Fund a **[**managed care ombudsman**]** Healthcare Advocate account that shall be a separate nonlapsing account. Any funds received under this section shall, upon deposit in the General Fund, be credited to said account and may be used by the Office of **[**Managed Care Ombudsman**]** the Healthcare Advocate in the performance of its duties.

Sec. 16. Section 38a-1049 of the general statutes is repealed and the following is substituted in lieu thereof (*Effective October 1, 2005*):

(a) There is established an advisory committee to the Office of **[**Managed Care Ombudsman**]** Healthcare Advocate which shall meet four times a year with the **[**Managed Care Ombudsman**]** Healthcare Advocate and the staff of the Office of **[**Managed Care Ombudsman**]** the Healthcare Advocate to review and assess the performance of the Office of **[**Managed Care Ombudsman**]** the Healthcare Advocate. The advisory committee shall consist of six members appointed one each by the president pro tempore of the Senate, the speaker of the House of Representatives, the majority leader of the Senate, the majority leader of the House of Representatives, the minority leader of the Senate and the minority leader of the House of Representatives. Each member of the advisory committee shall serve a term of five years and may be reappointed at the conclusion of that term. All initial appointments to the advisory committee shall be made not later than March 1, 2000.

(b) The advisory committee shall make an annual evaluation of the effectiveness of the Office of **[**Managed Care Ombudsman**]** Healthcare Advocate and shall submit the evaluation to the Governor and the joint standing committees of the General Assembly having cognizance of matters relating to public health and insurance not later than

February first of each year commencing February 1, 2001.

Sec. 17. Section 38a-1050 of the general statutes is repealed and the following is substituted in lieu thereof (*Effective October 1, 2005*):

The **[**Managed Care Ombudsman**]** Healthcare Advocate shall submit, not later than January first of each year, a report to the Governor and the joint standing committees of the General Assembly having cognizance of matters relating to public health and insurance concerning the activities of the **[**ombudsman**]** Healthcare Advocate. The report shall include, but not be limited to, information regarding: (1) The subject matter, disposition and number of consumer complaints processed by the **[**ombudsman**]** Healthcare Advocate; (2) common problems and concerns discerned by the **[**ombudsman**]** Healthcare Advocate from the consumer complaints and other relevant sources; (3) the need, if any, for administrative, legislative or executive remedies to assist consumers; and (4) the fiscal accounts of the Office of **[**Managed Care Ombudsman**]** the Healthcare Advocate.

Approved June 7, 2005